FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: South Dakota
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) CHIP and CHIP-NM

SCHIP Program Type ____ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
__X__ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program ' s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ›NC: for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

Since July 1, 1998 South Dakota has provided SCHIP benefits to uninsured children by providing expanded eligibility under the State's Medicaid plan. The initial M-SCHIP program, known as CHIP-M, was approved on August 5, 1998, and a subsequent eligibility expansion with Medicaid occurred on April 1, 1999.

A Title XXI State plan amendment added a separate State operated SCHIP program (S-SCHIP) that was implemented July 1, 2000. The S-SCHIP program targets uninsured children from families with income levels higher than were currently approved under the M-SCHIP eligibility levels.

1. Program eligibility

NC in the M-SCHIP.

In order to enroll more uninsured children a separate State operated S-SCHIP program, known in South Dakota as CHIP-NM, was implemented effective July 1, 2000. The new S-SCHIP covers uninsured children 0 through 18 years of age whose family income is between 141-200 % FPL.

2. Enrollment process

Minor revisions were made to the 301-M application to accommodate the S-SCHIP and M-SCHIP programs.
Attachment # 1: 301-M application

The State CHIP web site, http://www.state.sd.us/social/medicaid/chip/,was revised to include an application on line that can be printed off, completed, and faxed, mailed, or hand delivered to the local Department of Social Service office. This application can be used for both the M-SCHIP and S-SCHIP programs.

3. Presumptive eligibility

NC in M-SCHIP.

S-SCHIP follows the same rules as M-SCHIP in that there is no presumptive eligibility.

4. Continuous eligibility

NC in M-SCHIP.

S-SCHIP follows the same rules as M-SCHIP in that there is no continuous eligibility.

5. Outreach/marketing campaigns

The Community Healthcare Association of Sioux Falls, South Dakota was a successful applicant for the "South Dakota Covering Kids Initiative" through grant funding from the Robert Wood Johnson foundation for a three-year period of time from July 1, 2000 through June 30, 2003. The South Dakota Covering Kids Initiative has four goals. They are: designing and conducting outreach programs to identify and enroll children in the Medicaid and SCHIP programs; continuing to simplify access to and completion of enrollment information and applications; assisting in coordinating coverage programs for low income, uninsured children; and designing programming specifically targeted to Native Americans and other special populations. The program will feature statewide initiatives to meet these goals and also pilot programs to address specific geographic areas and special populations.

6. Eligibility determination process

Administrative changes to the eligibility process for all applicants were some of the most significant improvements made with the implementation of SCHIP. Notable among these administrative changes were the development of a new, shorter application form for medical assistance, dropping the requirement for face to face interviews, elimination of assets testing, reduced documentation requirements and direction for Department of Social Services(DSS) eligibility staff to actively participate in program outreach.

The new application form for Medicaid children, M-SCHIP, and S-SCHIP eligibility has been reduced to 3 pages from a form that had been over 30 pages in length. In addition to the shortening of the form, and eliminating assets information the new form also has reduced documentation requirement's as only earnings and childcare expenses need to be verified by the applicant family.

The completed eligibility forms may be mailed, faxed, or hand delivered to DSS eligibility offices

without the need for a face to face interview. However, DSS caseworkers are available at DSS offices to assist with completing the applications if necessary or requested. Workers at some outreach sites are also trained to assist with basic questions regarding Medicaid, M-SCHIP and S-SCHIP eligibility.

NC in M-SCHIP.

S-SCHIP follows the same rules as M-SCHIP.

7. Eligibility redetermination process

Future plans are to create a simplified and shortened redetermination form in order to assure continuous coverage of eligible children in both the M-SCHIP and S-SCHIP programs.

8. Benefit structure

NC in M-SCHIP

For S-SCHIP, services provided are identical to the benefits covered under the South Dakota Medicaid program for low-income children in amount, scope and duration. As such the benefits include all mandatory Medicaid services for the categorically needy and Early and Periodic Screening, and Treatment Services (EPSDT) benefits as well as all the optional services covered under the South Dakota Medicaid program.

Generally, all services provided under the Medicaid program must be "medically necessary". S-SCHIP services must also meet the requirements of the definition of medically necessary used by Medicaid. See 1.1.11 for definition of medically necessary services.

9. Cost-sharing policies

State plan amendments were approved on November 21, 2000 for Title XIX, and November 30, 2000 for the original M-SCHIP program to eliminate cost share requirements for 18 year olds. Therefore, there is no cost share requirements for any medical assistance recipients 18 years old and under.

The State is awaiting approval on the submitted S-SCHIP state plan. There will be no cost sharing imposed on 18 year olds in the S-SCHIP plan.

10. Crowd-out policies

NC for M-SCHIP.

S-SCHIP has specific measures to prevent the program from substituting for coverage under group health plans. The first measure is simply that persons covered by insurance providing hospital and medical services or HMO's are not eligible for benefits under the S-SCHIP program. Another measure to prevent substitution is that children are ineligible if they have been covered by a group health plan in the 3 months immediately preceding the application for S-SCHIP. The Department has adopted a definition of group health plan that includes employers, self-employed plans, employee organizations, and self insured plans that provide health care directly or otherwise. There are exceptions to the 3-month rule when the parents providing the insurance die, become disabled, lose their jobs, or start new jobs without coverage. Exceptions will also be made if care is not accessible under the group plan, or group plan coverage costs more than 5% of the S-SCHIP family's gross income.

The Department also requires that insurance information on the persons seeking medical assistance coverage be provided on the application for S-SCHIP as a measure to avoid substitution for group health coverage. The Department also requires that members of the S-SCHIP unit cooperate with the Department to determine the availability of coverage. Failure to cooperate may result in loss of eligibility for the unit.

11. Delivery system

NC for M-SCHIP.

Most medical services provided to children under South Dakota Medicaid are accessed through a primary care case management managed care system approved for Medicaid under a 1915(b) waiver. Children eligible for services under the S-SCHIP program will also be required to participate in the primary care case management system (PCCM). Under this program, a primary care physician (PCP) provides primary care services. Specialty services within the scope of the managed care program require a referral from the PCP, emergency services, family planning services, and non-medical services (dental, chiropractic, optometry, podiatry, immunization and transportation), are exempt from all PCCM requirements. Non-waiver services are accessed directly by recipients. All services are reimbursed on a fee for service basis. There is no cost sharing for services provided to children under this plan.
Attachment # 2: Managed Care Waiver 1915(b)

Generally, all services provided under the Medicaid program must be "medically necessary". S-SCHIP services must also meet the requirements of the definition of medically necessary used by Medicaid. Medically necessary services are those that:

- are consistent with the recipient's symptoms, diagnosis, condition, or injury
- are recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group
- are provided in response to a life-threatening condition; to treat pain injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition
- are not furnished primarily for the convenience of the recipient or the provider
- there is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

12. Coordination with other programs (especially private insurance and Medicaid)

The key programs providing creditable coverage for low-income children in South Dakota are the Medicaid and M-SCHIP programs that are jointly administered with the S-SCHIP program.

The new S-SCHIP program is a state administered program that is administered by the same agency and same staff as the existing Medicaid and M-SCHIP programs. There is no other State efforts for creditable health coverage programs. The new Title XXI program or S-SCHIP is intended to reach children of higher income levels than children currently covered under Medicaid and M-SCHIP. The joint administration and delivery of the program assures that only eligible, targeted low-income children will be enrolled in the new program. The new S-SCHIP program will share all of the functions with Medicaid and M-SCHIP efforts that have been established so far under South Dakota's M-SCHIP program.

The Indian Health Service (IHS) continues as a provider of creditable coverage to Indian children. The IHS functions as a provider of services and also provides coverage for certain specialty services through their contract health program. Coordination with the S-SCHIP program will continue in the same way as coordination with the Medicaid and M-SCHIP program. The IHS will be reimbursed for the direct services they provide to the S-SCHIP children at the same rate of payment as the South Dakota Medicaid program. Since the IHS contract care program is the payer of last resort under Federal Regulations, the S-SCHIP program will be primary to IHS contract care. Benefit coordination will be accomplished by the IHS denying claims they receive and causing the claims to be submitted to the S-SCHIP program for payment just as currently happens with Medicaid and M-SCHIP. Payment for those services under the S-SCHIP program will be on the same basis as established for the Medicaid and M-SCHIP programs.

The IHS also plays a very important role in the delivery of outreach services to facilitate the identification and enrollment of children for Medicaid and M-SCHIP. This role will continue for

potentially eligible S-SCHIP children using the established means to interface with the Department of Social Services medical assistance programs.

There are no other public programs providing creditable coverage to low-income children. Children potentially eligible for other public programs will be referred to those programs for services in addition to those provided by Medicaid, M-SCHIP or S-SCHIP.

Children covered by Medicare will not be enrolled in S-SCHIP as they have creditable Coverage.

Also see section 1.1.5: Outreach/Marketing campaigns.

13. Screen and enroll process

NC in M-SCHIP.

S-SCHIP will utilize the same application form and application procedures that are currently used for persons applying for Medicaid and M-SCHIP. This includes the availability of application forms, the same information and verifications being required, the same procedures to deliver the completed forms to the Department of Social Services, and the same Department of Social Services offices for assistance. Individuals applying for assistance will only indicate that they are requesting medical assistance, they will not be able to request a specific program. In this way, families are informed of all of the coverage opportunities made available for uninsured children.

Through information provided on the completed application form the Department of Social Services caseworker will determine the appropriate program of enrollment, if any, for the applicants.

All applications and enrollments will also be processed on a statewide computer system shared with Medicaid and M-SCHIP eligibility. This will assure uniform eligibility methods statewide, that individuals are enrolled in only one program of coverage at any time, and make use of a statewide database to assist caseworkers in making correct eligibility decisions. The shared database may include information on current and previous program enrollments, reported income, or insurance coverage for use in evaluating SCHIP applications. An electronic worksheet assists the case workers in determining the correct assignment of programs so individuals will be correctly assigned to Medicaid, M-SCHIP or S-SCHIP.

14. Application

Minor revisions were made to the 301-M application to accommodate the S-SCHIP. The same application is used for Medicaid, M-SCHIP and S-SCHIP.

Attachment # 1: 301-M application

The State CHIP web site, http://www.state.sd.us/social/medicaid/chip/,was revised to include a CHIP application on line that can be printed off, completed, and faxed, mailed, or hand delivered to the local Department of Social Service office. This application can be used for both the M-SCHIP and S-SCHIP programs.

15. Other

NC

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

The following table shows the percentage reduction in the number of uninsured children following each federal fiscal year of SCHIP operation. It also shows the overall reduction of uninsured children since the implementation of SCHIP July 1, 1998.

Period	1998 Estimate of Uninsured Children	Medicaid Increase (children with out insurance)	M-SCHIP Increase (Program began 07-01-98)	S-SCHIP Increase (Program began 07-01-00)	Total	Remaining Uninsured Children	Percentage Reduction in Uninsured Children
FFY 98 07/01/1998-09-30-1998	13,000	1,188	903		2,091	1999 - 10,909	16%
FFY 99 10-01-1998-09-30-1999		2,381	1,585		3,966	2000 - 6,942	36%
FFY 00 10-01-1999-		2,265	1,891	301	4,457	2001 - 2,486	64%

09-30-2000							
From SCHIP implementation: 07-01-98-09-30-00		5,834	4,379	301	10,514	2,486	81%

In the FFY '00 we estimate there has been a 64% reduction in the uninsured children , and estimate there has been an 81% reduction in uninsured children since 07-01-98, the implementation of SCHIP. This estimate is arrived at from using 96-97-98 Current Population Survey data (13,000 low income uninsured children at or below 200% of Poverty) and enrollment data.

In FFY 2000 we have added 4,457 uninsured children to Medicaid, M-SCHIP, and S-SCHIP. Data is from the South Dakota Medicaid and SCHIP programs enrollment data.

1. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

The following table reports the number of enrolled Medicaid, M-SCHIP and S-SCHIP children for the ending date of each quarter from M-SCHIP and S-SCHIP implementation to the end of Federal Fiscal Year 2000. Throughout this report when the number of Medicaid eligible children is referred to, it includes all categories of Medicaid eligible children except SSI Medicaid eligible children.

Quarter Ending	Medicaid Children	M-SCHIP Children (Implemented 07-01-1998)	S-SCHIP Children (Implemented 07-01-2000)
06/30/1998 *	32,859	-0-	-0-
09/30/1998 (4th Quarter FFY' 98)	34,290	903	-0-
12/31/1998	35,320	1,407	-0-
03/31/1999	36,435	1,710	-0-
06/30/1999	36,866	2,039	-0-
09/30/1999 (4th Quarter FFY' 99)	37,158	2,488	-0-
12/30/1999	37,768	2,790	-0-
03/31/2000	39,195	3,179	-0-
06/30/2000	39,538	3,725	-0-
09/30/2000 (4th Quarter FFY' 00)	39,887	4,380	301

* Last Quarter Prior to M-SCHIP and S-SCHIP Implementation.
Source: South Dakota MMIS 1998, 1999, 2000

Extracted data from the MMIS over this time period revealed that 83% of the children enrolled in Medicaid were uninsured when considering all types of insurance including full coverage, and limited coverage plans including hospital only, dental and cancer. All M-SCHIP and S-SCHIP children were by definition, uninsured.

1. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State

The enrollment data in the table in 1.1.2 shows that there has been an increase in Medicaid of 7,028 children, 4,380 children enrolled in M-SCHIP, and 301 children enrolled in S-SCHIP for a total increase of 11,709 children that have insurance coverage since the inception of SCHIP July 1, 1998.

Also see table in 1.2.1.

2. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

_____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

The Census Bureau Current Population Survey, based upon its three year averages for 1997, 1998, and 1999, reported 13,000 uninsured children under 200% of the FPL for South Dakota.

What was the justification for adopting a different methodology?

NC (have not adopted a different methodology).

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The State believes the CPS estimate is the best source of baseline data available for the number of uninsured children and the use of Medicaid and SCHIP actual enrollment data is very reliable.

Had your state not changed its baseline, how much progress would have been made in reducing

the number of low-income, uninsured children?

NA (no change in baseline number estimate).

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1:	List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2:	List the performance goals for each strategic objective.
Column 3:	For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Achieve a measurable reduction in the number of uninsured children in South Dakota A) South Dakota is implementing S-SCHIP as an additional effort to address the objectives stated in the original state plan effective July 1, 2000 and each objective will include the S-SCHIP program.	3. M-SCHIP: Implement Medicaid expansion to cover uninsured children age 6 through 18 to 133% FPL through a CHIP State Plan on 07-01-1998, enrolling 7,352 children by 06-30-1999 and increasing enrollment by 5% each year after the initial year. S-SCHIP: South Dakota is implementing S-SCHIP as an additional effort to address the objectives stated in the original state plan effective July 1, 2000. Implement S-SCHIP to provide coverage to an additional 2,400 targeted, uninsured children in families with	1. Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS & MR 63: June 1998 - September 2000. Methodology: Reduce 1998 CPS base line by actual enrollments in M-SCHIP. Progress Summary: FFY 1998 M-SCHIP enrollment 903 FFY 1999 M-SCHIP enrollment 1,585 FFY 2000 M-SCHIP enrollment 1,891 FFY 2000 S-SCHIP enrollment 301 Reduction in M-SCHIP uninsured children FFY 1998 7% Reduction in M-SCHIP uninsured children FFY 1999 15% Reduction in M-SCHIP uninsured children FFY 2000 27% Reduction in S-SCHIP uninsured children FFY 2000 4% Narrative: An M-SCHIP plan was developed and submitted to HCFA on 06-05-1998 with approval being received on 08-25-1998. The plan was implemented on July 1, 1998.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	incomes from 140% to 200% of the federal poverty level beginning July 1, 2000.	
	4. Extend Medicaid to uninsured children age zero through eighteen at Medicaid eligibility levels in effect prior to 07-01-98, enrolling 900 additional children by 06-30-99 and increasing enrollment by 1% each year after the initial year.	2. Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS & MR 63: June 1998 - September 2000. Methodology: Reduce 1998 CPS baseline by actual enrollments in Medicaid. Progress Summary: FFY 1998 Medicaid enrollment increase 1,188 FFY 1999 Medicaid enrollment increase 2,381 FFY 2000 Medicaid enrollment increase 2,265 Reduction in uninsured children FFY 1998 9% Reduction in uninsured children FFY 1999 22% Reduction in uninsured children FFY 2000 33%
	5. M-SCHIP: Utilize a systematic approach to identify uninsured children with low	3. NC, however the Community Healthcare Association of Sioux Falls, South Dakota was a successful applicant for the "South Dakota Covering Kids Initiative" through grant funding from the Robert Wood Johnson foundation for a three-year period of time from July 1, 2000

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	incomes using Department data resources, partnerships with other public programs, and local involvement of interested parties including schools, providers, and others by July 1, 1998 and continuing each year. S-SCHIP: Continue to utilize a systematic approach to identify uninsured children with low incomes using Department data resources, partnerships with other public programs, and local involvement of interested parties including schools, providers, and others. 6. Simplify the Medicaid application process for low-income children using a shortened	through June 30, 2003. The South Dakota Covering Kids Initiative has four goals. They are: designing and conducting outreach programs to identify and enroll children in the Medicaid and SCHIP programs; continuing to simplify access to and completion of enrollment information and applications; assisting in coordinating coverage programs for low income, uninsured children; and designing programming specifically targeted to Native Americans and other special populations. The program will feature statewide initiatives to meet these goals and also pilot programs to address specific geographic areas and special population S-CHIP: S-SCHIP will share all of the functions with Medicaid and M-SCHIP efforts that have been established so far under South Dakota's M-SCHIP program. The strategy of joint program administration also provides for inclusion of the S-SCHIP program in all of the outreach efforts currently being conducted by the Department. This will ensure that all potential clients will receive complete information on the medical assistance program and requirements for participation in the program. 4. NC, however applications can also be faxed into the local DSS offices. The application is also on the Web site and may be completed, printed off, and mailed, faxed, or hand delivered to the local DSS offices. Web site address is: www.state.sd.us/soscial/medicaid/chip.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	application and accepting mail-in applications by July 1, 1998. S-SCHIP: Expand the simplified medical assistance application process to include S-SCHIP the same as the Medicaid and M-SCHIP medical assistance programs. 7. Increase the number of Department of Social Services personnel to support the enrollment of uninsured children by 12 full time equivalent workers by June 30, 1999.	 S-SCHIP: S-SCHIP will utilize the same application form and application procedures that are currently used for persons applying for low income Medicaid and M-SCHIP. This includes the availability of application forms, the same information and verifications being required, the same procedures to deliver the completed forms to the Department, and the same Department of Social Services offices for assistance. 5. NC for M-SCHIP
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
M-SCHIP and S-SCHIP: Achieve a measurable reduction in the number	M-SCHIP: Implement Medicaid expansion to cover uninsured children	Narrative: An M-SCHIP plan was developed and submitted to HCFA on 06-05-1998 with approval being received on 08-25-98. The plan was implemented on July 1, 1998. Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
of uninsured children in South Dakota.	age 6 through 18 to 133% FPL through a CHIP State Plan on 07-01-1998, enrolling 7,352 children by 06-30-1999 and increasing enrollment by 5% each year after the initial year. S-SCHIP: South Dakota is implementing S-SCHIP as an additional effort to address the objectives s stated in the original state plan effective July 1, 2000. Implement S-SCHIP to provide coverage to an additional 2,400 targeted, uninsured children in families with incomes from 140% to 200% of the federal poverty level beginning July 1, 2000.	SD MMIS & MR 63: June 1998 - September 2000. Methodology: Reduce 1998 CPS baseline by actual enrollments in M-SCHIP. Progress Summary: FFY 1998 M-SCHIP enrollment 903 FFY 1999 M-SCHIP enrollment 1,585 FFY 2000 M-SCHIP enrollment 1,891 Reduction in M-SCHIP uninsured children FFY 1998 7% Reduction in M-SCHIP uninsured children FFY 1999 15% Reduction in M-SCHIP uninsured children FFY 2000 27% Narrative: In the FFY '00 we estimate there has been a 64% reduction in the uninsured children (4% - S-SCHIP, 27% - M-SCHIP, and 33% Medicaid), and estimate there has been an 81 % reduction in uninsured children since 07-01-98, the implementation of SCHIP. This estimate is arrived at from using 96-97-98 Current Population survey date (13,000 low income uninsured children at or below 200% of Poverty) and enrollment data.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Achieve a measurable reduction in the number of uninsured children in	Extend Medicaid to uninsured children age zero through eighteen at	Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS & MR 63: June 1998 - September 2000.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
South Dakota.	Medicaid eligibility levels in effect prior to 07-01-98, enrolling 900 additional children by 06-30-99 and increasing enrollment by 1% each year after the initial year.	Methodology: Reduce 1998 CPS baseline by actual enrollments in Medicaid. Progress Summary: FFY 1998 Medicaid enrollment increase 1,188 FFY 1999 Medicaid enrollment increase 2,381 FFY 2000 Medicaid enrollment increase 2,265 Reduction in uninsured children FFY 1998 9% Reduction in uninsured children FFY 1999 22% Reduction in uninsured children FFY 2000 33% Narrative: In the FFY '00 we estimate there has been a 64% reduction in the uninsured children (4% - S-SCHIP, 27% - M-SCHIP, and 33% Medicaid), and estimate there has been an 81 % reduction in uninsured children since 07-01-98, the implementation of SCHIP. This estimate is arrived at from using 96-97-98 Current Population survey date (13,000 low income uninsured children at or below 200% of Poverty) and enrollment data.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Improve access to quality primary and preventative health care	M-SCHIP: Enroll all newly approved M-SCHIP children in the South Dakota	Data Sources: NC for M-SCHIP Methodology: NC for M-SCHIP

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
services under Medicaid for SCHIP eligibles, new Medicaid eligibles, and previously non-enrolled children on July 1, 1998 .	Medicaid primary care case management program within 1 month of their enrollment, beginning 07-01-98. S-SCHIP: Enroll 95% of all newly approved S-SCHIP children in the South Dakota medical assistance primary care case management program with 1 month of their enrollment, beginning July 1, 2000	Progress Summary: For FFY 2000 the M-SCHIP managed care participation rate is 99.5 %. The March 2000 report showed a 98.6% average participation rate. S-SCHIP: Data Sources: Local eligibility workers and Managed Care System Methodology: Average Managed Care Participation for S-SCHIP enrollees. Averages based on enrollment numbers from 07-01-00 through 09-30-00. July 2000 enrollment numbers were excluded due to the PCP selection time period enrollees are permitted. Progress Summary: In studying the Managed Care participation for the three months that S-SCHIP has been in operation, the average participation rate is 99.9%.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
Improve access to quality primary and preventative health care services under Medicaid for SCHIP eligiblies, new Medicaid eligiblees, and previously non-enrolled children..	1. Ensure each new SCHIP enrollee and new Medicaid eligibles receive EPSDT information at the time their eligibility is approved.	Data Sources: NC in M-SCHIP, and S-SCHIP enrollees will receive the same information as Medicaid and M-SCHIP enrollees as part of the enrollment process. Methodology: NC Progress Summary: The parent reminder letter that is sent out from the Department to Medicaid and SCHIP households was revised and implementation of the revised letter began September, 2000. The Health Kids Klub brochure that is given to parents/care takers of children that become eligible was also revised and put into use September, 2000. Attachment # 15: Previous and Revised Parent /Care taker reminder letter (EPSDT reminder letter) and the Healthy Kids Klub brochure.
	2. Develop a quality measurement mechanism that includes measures of immunization, well childcare, adolescent well care, satisfaction and other measures of health care equality.	1. Data Source: NC in M-SCHIP, and S-SCHIP will be included in studies that are done. Methodology: NC Progress Summary: Measures completed for each of the identified performance measures in the state plan. Attachments # 3 through # 9, # 12 , # 13: # 3 Immunization Study; # 4 Well Child Visit Study; # 5 Optometric Study; # 6 Mental Health Study/Eating Disorder Study; # 7 Asthma Study; # 8 Substance Abuse Study; # 9 Dental Study; # 12 Satisfaction of Health Care/Department Survey 2000; # 13 Department SCHIP Survey Comparison Chart - 1998-1999-2000,
OTHER OBJECTIVES		
Develop better	1. Develop survey	1. Data Sources: NC in M-SCHIP and S-SCHIP is included in this objective.

measurement capabilities of health insurance coverage, health care service availability and quality to children in South Dakota.	capabilities with the Department of Health to measure the insurance coverage of children in South Dakota by 07-01-98. 2. Modify the MMIS to make M-SCHIP tracking and reporting capabilities available to measure enrollment, service, utilization, and overall program effectiveness. 3. Develop capability to measure access to coverage for Indian children in South Dakota by working jointly with the Indian Health Service, Tribal governments and Urban Indian Health clinics by 07-01-00.	Methodology: NC Progress Summary: BRFSS information from the Department of Health 2. Data Sources: NC for M-SCHIP and S-SCHIP has been included into the reporting mechanisms. Methodology: NC Progress Summary: NC 3. Data Sources: NC in M-SCHIP and S-SCHIP will be included in M-SCHIP objectives. Methodology: NC Progress Summary: NC , will continue to maintain a data base on the number and location of providers including IHS and UIH facilities that serve as PCP's to our managed care recipients. Ongoing efforts to develop an information exchange system with IHS facilities to utilize their immunization data for our statewide immunization project. S-SCHIP will be included in this. All 20 IHS facilities in South Dakota and 1 IHS facility in North Dakota along with three UIH facilities in the state are participating as PCP's. The American Indian M-SCHIP and S-SCHIP recipients are given the opportunity to select the PCP of their choice. They can receive services at IHS facilities even if they have not selected those providers as their PCP. Attachment # 20: Indian Health Service Primary Care Provider (PCP) List Narrative: There are 40.1% or 398 out of 992 American Indian M-SCHIP recipients using IHS and UIH facilities as of 09-01-00. There are 56.0% or 14 out of 25

		American Indian S-SCHIP recipients using IHS and UIH facilities as of 09-01-00.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Since the SCHIP programs have only been in operation for a short time, it is difficult to draw any significant conclusions about our SCHIP population at this time. As studies continue to be done, comparisons will be made and reported on in the next reporting requirement.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

NA

1.5 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

M-SCHIP and S-SCHIP enrollees are included in the Medicaid waiver and they will be included in the operation of the waiver.
Attachment # 2: Managed Care Waiver 1915(b)

Department surveys with questions relating to access of care and satisfaction of care will continue to be sent to households of M-SCHIP and S-SCHIP recipients. We will continue to survey on a periodic basis. Future survey results will be included with the next reporting requirement.
Attachment # 10: Department SCHIP Survey 1998
Attachment # 11: Department SCHIP Survey 1999
Attachment # 12: Department SCHIP Survey 2000
Attachment # 13: Department SCHIP Survey Comparison Chart - 1998-1999-2000

The departments managed care area currently conducts quality assurance studies in a number of areas. Examples of the studies for SCHIP recipients that have been completed include: Immunization, Well Child Visits, Optometric Services, Mental Health/Eating Disorders, Asthma, Substance Abuse, and Dental Services. We will continue these Quality Assurance studies and will pursue action to obtain measurable improvement. Future study results will be included with the next reporting requirement.
Attachment # 3: Immunization Study
Attachment # 4: Well Child Visit Study
Attachment # 5: Optometric Study
Attachment # 6: Mental Health/Eating Disorder Study
Attachment # 7: Asthma Study
Attachment # 8: Substance Abuse Study
Attachment # 9: Dental Study

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment,

access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Attachment 1: 301-M application
Attachment 2: South Dakota Managed Care waiver 1915 (b)
Attachment 3: Immunization Study
Attachment 4: Well Child Visit Study
Attachment 5: Optometric Study
Attachment 6: Mental Health Study/Eating Disorder Study
Attachment 7: Asthma Study
Attachment 8: Substance Abuse Study
Attachment 9: Dental Study'
Attachment 10: Department SCHIP Survey 1998
Attachment 11: Department SCHIP Survey 1999
Attachment 12: Department SCHIP Survey 2000
Attachment 13: Department SCHIP Survey Comparison Chart - 1998, 1999, 2000
Attachment 14: Radio Announcement and Coverage Area Maps
Attachment 15: Healthy Kids Klub brochure and Parent Reminder Letters
Attachment 16: FFY 2000 HCFA-64.EC, HCFA-64.21 E, HCFA-21E.
Attachment 17: FFY 2000 HCFA-64.21U
Attachment 18: Disenrollee Survey
Attachment 19: Primary Care Participation enrollment averages
Attachment 20: Indian Health Service Primary Care Provider (PCP) list
Attachment 21: Crowd Out Analysis

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

N/A

1. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

N/A

Number of adults_____
Number of children_____

2. How do you monitor cost-effectiveness of family coverage?

N/A

1 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

N/A

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

N/A

Number of adults_____
Number of children_____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?
NC for M-SCHIP.

Crowd out is defined as the act of replacing existing private or group health insurance with State-Federal funded medical assistance.

2. How do you monitor and measure whether crowd-out is occurring?

The Department requires that insurance information on the persons seeking medical assistance coverage be provided on the application for SCHIP as a measure to avoid substitution for group health coverage. The Department also requires that members of the SCHIP unit cooperates with the Department to determine the availability of coverage. Failure to cooperate may result in loss of eligibility.

The Department also maintains a database on persons with insurance coverage for persons applying for or receiving medical assistance from the Department under Medicaid, M-SCHIP or S-SCHIP. The database includes type of coverage, name and address of carrier, policy numbers, plan sponsor, premium payer, and dates of coverage. Information from this database is available to caseworkers to explore potential group health coverage. Caseworkers also have the opportunity to update the information on this database to keep the information up to date.

South Dakota will continue to study the effects of its enrollment policies on the possible substitution of SCHIP coverage for private group coverage.

The Department of Social Services developed and administered a random survey containing questions relating to insurance coverage to address crowd out. The results of the 1998 survey showed that only a small number, 3 out of 82, dropped their private health insurance because M-SCHIP was available. The December 1999 Department SCHIP survey results showed that out of 305 responses, 3 indicated they had dropped insurance because of the availability of M-SCHIP for a rate of 1%. In the November 2000 Department SCHIP survey, sent to both M-SCHIP and S-SCHIP households, out of 266 responses 1 responded that they had dropped their insurance for the SCHIP program, for a rate of 0.3%. When we compare the results from the 1998, 1999, and 2000 surveys, we find that the numbers of respondents that have dropped their insurance coverage due to the SCHIP programs is low and actually decreased in the second year, and decreased again in the third year of operation. We are aware of this as an important issue and plan to continue monitoring this.
Attachment # 10: Department SCHIP Survey 1998
Attachment # 11: Department SCHIP Survey 1999
Attachment # 12: Department SCHIP Survey 2000
Attachment # 13. Department SCHIP Comparison Chart - 1998, 1999, 2000.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

NC for M-SCHIP.

Since the implementation of S-SCHIP on July 1, 2000 through this reporting period (09/30/2000), one child was identified as having dropped group health insurance. In accordance with South Dakota S-SCHIP policy, this child was found ineligible for S-SCHIP coverage.

This data is gathered and made available through the eligibility determination computer system. Attachment # 21: Crowd Out Analysis

Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Our program design provides no incentive for a family to drop insurance coverage because the children who are insured qualify for benefits under Medicaid and only the children who are uninsured are enrolled in SCHIP. In as much as families already made their decision to have insurance, additional benefits of having Medicaid insurance are still available to them.

S-SCHIP was implemented July 1, 2000. There are in place specific measures to prevent the program from substituting for coverage under group health plans. The first measure is simply that persons covered by insurance providing hospital and medical services or HMO's are not eligible for benefits under the S-SCHIP program. Another measure to prevent substitution is that children are ineligible if they have been covered by a group health plan in the 3 months immediately preceding the application for S-SCHIP. The Department has adopted a definition of group health plan that includes employers, self-employed plans, employee organizations, and self insured plans that provide health care directly or otherwise. There are exceptions to the 3-month rule when the parents providing the insurance die, become disabled, lose their jobs, or start new jobs without coverage. Exceptions will also be made if care is not accessible under the group plan, nor group plan coverage costs more than 5% of the S-SCHIP family's gross income. South Dakota will continue to study the effects of its enrollment policies on the possible substitution of S-SCHIP coverage for private group coverage.

2.4 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

- Having applications and information available to medical providers and churches, especially those located in areas where many lower income families live including Free clinics and Community Health Centers.

- Cooperation from school nurses and Head Start programs as they work with individual children in getting SCHIP information out to the families of all students.
- Involvement in Health fairs, etc in the local communities.
- Television media stories on changes with the SCHIP program.
- Setting up SCHIP displays at Parent-Teacher conferences.
- Specific groups/organizations such as Physician Assistant students that took SCHIP outreach on as a service project.
- Staying in contact with places that have previously had outreach done and making sure they have updated material and a supply of applications.

The SCHIP Department survey has questions relating to where applicants heard about the program and where they obtained the application. The survey done in November, 2000 showed that 47% heard about the SCHIP program from the Department of Social Services, compared to 55% in the 1999 survey and 76.1% in the 1998 survey. This decrease in percentage shows that families are learning about the SCHIP program from a variety of sources as opposed to the majority learning about it through Social Services as in 1998.

Attachment # 13: Department SCHIP Survey Comparison - 1998, 1999, and 2000.

The SCHIP Department Survey 2000 results also revealed that 80.9% of the applications for SCHIP were obtained from the Department of Social Services as compared to 86% in 1999 and 93% in 1998. The decrease in percentages in this area also shows that applications are being obtained from sources other than the Department of Social Services than in the previous studies.

A specific increase in phone call inquiries asking for applications was seen following television new stories on SCHIP.

1. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

   In general we have found that on the Reservations, the most successful outreach has been coordination with IHS and Tribal governments.

   To measure effectiveness, some areas have marked applications given out by school nurses, Head Start programs, hospitals, health fairs, etc. However, some families that learn about the SCHIP program from these locations did not always take the marked applications, but instead got an unmarked application from another source.

   Some areas have measured effectiveness based on the percentage of families in Head Start who actually make application for Medical assistance compared to the number of families in Head Start who were informed about the program. This percentage is relatively high compared to other Outreach contacts.

2. Which methods best reached which populations? How have you measured effectiveness?

IHS and Tribal medical providers help reach American Indian populations. Contacts with health providers at the various vocational schools, colleges, and universities have been useful in reaching non-traditional students and those under 19 who are on their own. Contacts with the various Birth -to-Three agencies (previously called Interagency Coordinating Councils) have also resulted in referrals of eligible children.

Brochures and application packets have worked the best with these contacts as they can keep them and provide them to families that they are in contact with. The application on the Web site will be an excellent method for reaching families as more families get access to the Internet.

The only way that we can measure effectiveness with these families is with anecdotal information of how they learned about the program. Local offices keep track of Internet applications as they are aware of them.

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

The Department is developing a simplified re-determination form that will be used by Medicaid, M-SCHIP and S-SCHIP categories. Completion and implementation for this form is planned for November, 2000.
The Department plans to develop a quality control pilot where families who have gone off SCHIP will be contacted and assessed as to methods that may have resulted in the family keeping eligible children enrolled in the program. Implementations for this project is projected to begin in late fall 2000.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__X__ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
__X__ Targeted mailing to selected populations, specify population __Households with Disenrolled children__
__X__ Information campaigns
__X__ Simplification of re-enrollment process, please describe __In planning stage for implementation fall 2000.__
__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe __Disenrollee survey implemented 09-2000__
____ Other, please explain_____

Are the same measures being used in Medicaid as well? If not, please describe the differences.

The same measures listed in 2.5.2 are being used in Medicaid with the exception of disenrollee surveys. The disenrollee surveys were implemented September, 2000 and are currently only being sent to SCHIP disenrollee households.

3. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Eligibility staff screen all recipients for potential eligibility in any medical assistance program to ensure continuous enrollment.

4. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

The Disenrollee survey was implemented September, 2000. This survey is being sent out monthly to households were children have become disenrolled. Due to the limited time that this survey has been in use there is not enough data to draw a conclusion for the FFY '00 report, the data will be reported on in the next reporting requirement

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

NC in M-SCHIP

The S-SCHIP program will follow the same eligibility and re-determination process that is used by the Medicaid program for children and the existing M-SCHIP program. The process will begin with potentially eligible individuals obtaining and completing an application form obtained from the Department of Social Services, or from any of the many local entities that are participating with outreach for the Medicaid and M-SCHIP programs. The short application form must be completed and signed by the head of household or parent of the children. The forms may then be mailed, faxed or hand delivered to the client's local office from among the 41 Department of Social Services offices through out the State. Assistance in completing the forms is available from the Department of Social Services, including assistance for persons with Limited English Proficiency or disabilities.

Families applying for medical assistance, including the S-SCHIP program are provided with a pamphlet that explains S-SCHIP eligibility, and the scope of covered services. The pamphlets are written in accurate, easy to understand language to assist families in making a decision to apply for medical assistance.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

NC in M-SCHIP.

The S-SCHIP program shares all of the functions with Medicaid and M-SCHIP that have been established in South Dakota. S-SCHIP forms and procedures are identical to those utilized for Medicaid and M-SCHIP. This also includes utilization of the same staff to make eligibility determinations and a single computer eligibility determination system. Once a child is determined eligible for Medicaid, M-SCHIP, or S-SCHIP the eligibility remains until a determination has been made that the child is no longer eligible for Medicaid, M-SCHIP, or S-SCHIP. This seamless process allows children to transfer from one medical program to another without interruption when eligibility criteria changes, but the child remains eligible for Medicaid, M-SCHIP, or S-SCHIP.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

NC in M-SCHIP.

Health care services for S-SCHIP will be delivered using the existing Medicaid and M-SCHIP delivery and payment systems including primary care case management and access to specialty health service providers, as approved under the State's 1915(b) waiver under Medicaid. The State can assure that children receiving services under M-SCHIP and S-SCHIP will receive the same beneficiary protections as children receiving Medicaid coverage including grievances and appeals, privacy and confidentiality, respect and non-discrimination, access to emergency services, and an opportunity to participate in health care treatment decision and choice of providers. Benefits delivered to targeted uninsured children under the M-SCHIP and the S-SCHIP state administered programs are identical to the benefits offered under the State's Medicaid program, including EPSDT benefits. The State can also assure that it is providing SCHIP services in an effective and efficient manner by using Medicaid policies and procedures.

1 Cost Sharing:

State plan amendments were approved on November 21, 2000 for Title XIX, and November 30, 2000 for the original M-SCHIP program to eliminate cost share requirements for 18 year olds. Therefore, there is no cost share requirements for any medical assistance recipients 18 years old and under.

The State is awaiting approval on the submitted S-SCHIP state plan. There will be no cost sharing imposed on 18 year olds in the S-SCHIP plan.

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   NA

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

   NA

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

   M-SCHIP and S-SCHIP recipients are enrolled in the Primary Care Case Management (PCCM) program and become part of the managed care population. Since they are a part of the managed care program they benefit from the PCCM standards for access to and quality of care services. Most of the specialized physicians participate, all hospitals in the state participate, all IHS participates, pharmacies almost have universal participation and dental participation is 78%. The statewide PCP/enrollee ratio as of January 2000 is one provider to every 85 managed care recipients. See table below for the numbers of providers by specialty that are currently serving our managed care population that also includes M-SCHIP and S-SCHIP enrollees.

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
1. Pediatricians	55	53 (8 are out-of-state providers)	53
2. Family Practitioners	331	312 (61 are out-of-state providers)	312
3. Internists	181	93 (4 are out-of-state providers)	93
4. General Practitioners	Included w/FP's	Included w/FP's	
5. OB/GYN, and GYN	43	55 (1 is an out-of-state provider)	55
6. FQHCs	13	20 (1 is an out-of-state provider)	20
7. RHCs	34	58 (7 are out-of-state providers)	58
8. Nurse Practitioners			

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
9. Nurse Midwives			
10. Indian Health Service Clinics	15	21 (1 is an out-of-state provider)	21
Additional Types of Provider to be PCCMs			
1.Air Force Base Clinics	0	1	1

Time and distance standards are that no recipient in the state has to travel more then 75 miles to their Primary Care Provider (PCP). If they have to travel more then this distance, they may be exempt from managed care. Also, they are included in the managed care studies.

The Department of Social Services developed and administered a random survey that was sent out December 1998 to 167 households that had an eligible M-SCHIP recipient. This figure represented a 15% random sample that yielded a return rate of 51.5% or 86 responses. The return rates on the survey were comparable for white and Native American survey participants. In November 1999 another Department of Social Service M-SCHIP random survey was sent out to 544 households that had an eligible M-SCHIP recipient. This figure represented a 20% random sample and netted a return rate of 56.8%. Specific questions were again targeted to access to care and satisfaction. See attachments for survey results.
Attachment # 10: 1998 Department SCHIP Survey
Attachment # 11: 1999 Department SCHIP Survey

In November, 2000 a third Department survey was sent to a 20% random sample of 519 households that had an M-SCHIP or S-SCHIP recipient. The same survey tool that was used in the previous surveys was used for comparison purposes. The following results were noted.
Attachment # 12: 2000 Department SCHIP Survey

- 66.1% responded that their child had at least one visit for a routine well child care check up with their primary care provider, not related to illness or injury since enrollment in SCHIP.

- 56.9% reported their child had a dental examination since enrolling in the SCHIP programs. The second part of the question showed that 39.1% of the children needed dental care but did not receive it due to cost before being covered by SCHIP.

- 51.4% reported having a vision exam since being enrolled in SCHIP. Part two of the question showed 27.5% needed vision care but did not receive it due to cost before being covered by SCHIP.

- 97.2% responded they felt that the PCP was providing quality care for their child.

- 86.9% replied that they were able to get medical care for their child when it was needed.

In comparing the surveys the respondents consistently report that they are satisfied with the quality of care their child is receiving on the program. It should be noted that although children are receiving well childcare visits, this is one area where more information and education is needed to promote the preventative health care services that is available through this program. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) parent or caretaker reminder letters are sent out monthly as a reminder for well child visits and immunizations that are age appropriately due. This reminder letter and the Healthy Kids Klub brochure were revised July, 2000. A promotional campaign was launched regarding these changes that included collaboration with the Department of Health as well as departmental efforts. The Medicaid newsletter that goes to all providers included an article regarding the changes. A letter with a sample of the new parent letter and a Healthy Kids Klub brochure was sent to providers that care for children. The local Department of Social Services offices were updated with the new brochures that are included in the initial information that is given to families when children become eligible for the SCHIP programs. Implementation of the newly revised letters to the parents began September, 2000.
It is hoped that the new format and informational changes to the letters to parents will encourage and increase the use of these services.
Attachment # 15: Revised 7/00 Healthy Kids Klub parent letter; Revised 7/00 Healthy Kids Klub brochure; Prior to 7/00 Healthy Kids Klub parent letter; Prior to 7/00 Healthy Kids Klub brochure.

1. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

Since the M-SCHIP and S-SCHIP enrollees are included in the Medicaid managed care waiver they will be included in the operation of the waiver.

Department surveys with questions relating to access of care will continue to be sent to households of M-SCHIP and S-SCHIP recipients. We will continue to survey on a periodic basis.

Studies regarding utilization of services for well-child care visits, immunizations, mental health, substance abuse, dental, and vision will continue to be done on a periodic basis and the results will be included in the reporting requirements for SCHIP. See 1.7: Attachments.

2. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The M-SCHIP and S-SCHIP enrollees are included in the Medicaid waiver 1951(b) and are enrolled in the Primary Care Case Management (PCCM) system. Since they are a part of the managed care program they benefit from the same methods that exist for the Medicaid enrollees to assure quality and appropriateness of care.

The most comprehensive mechanism to be used by the State in the M-SCHIP and S-SCHIP program is the Primary Care Case Management system.

Department surveys with questions relating to access of care will continue to be sent to households of M-SCHIP and S-SCHIP recipients. We will continue to survey on a periodic basis.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible. Janet and Rick ideas?????

Note: If there is nothing to highlight as a success or barrier, Please enter ›NA: for not applicable.

1. Eligibility

Implemented S-SCHIP July 1, 2000. Children to be covered under the S-SCHIP program are uninsured children from birth to age 19 in families with incomes above 140% of the FPL and not exceeding 200% of the FPL. Children are considered uninsured if they do not qualify for Medicaid and have not had group health plan coverage in the three months immediately prior to application for S-SCHIP.

2. Outreach

Department of Social Services case workers continue to expand outreach efforts in their local communities reaching a diversified group including families, agencies, organizations, schools, and health care providers.

A radio campaign aired in September, 2000 promoting the SCHIP program. Attachment # 14: Radio ad and coverage maps.

The Community Healthcare Association of Sioux Falls, South Dakota was a successful applicant for the "South Dakota Covering Kids Initiative" through grant funding from the Robert Wood Johnson foundation for a three-year period of time from July 1, 2000 through June 30, 2003. The South Dakota Covering Kids Initiative has four goals. They are: designing and conducting outreach programs to identify and enroll children in the Medicaid and SCHIP programs; continuing to simplify access to and completion of enrollment information and applications; assisting in coordinating coverage programs for low income, uninsured children; and designing programming specifically targeted to Native Americans and other special populations. The program will feature statewide initiatives to meet these goals and also pilot programs to address specific geographic areas and special populations.

3. Enrollment

In FFY 2000 we added a total of 4,457 uninsured children to Medicaid, M-SCHIP, and S-SCHIP. Enrollment breakouts per category:

Medicaid = 2,265

M-SCHIP = 1,891
S-SCHIP = 301

Data is from the South Dakota Medicaid and SCHIP programs enrollment data.
See Table in 1.2.1.

3. Retention/disenrollment

   Disenrollee surveys were began September, 2000 to SCHIP participants that are no longer enrolled in the medical assistance program.

4. Benefit structure

   NA in M-SCHIP

   S-SCHIP utilizes the established Medicaid structure as does M-SCHIP.

5. Cost-sharing

   Elimination of cost sharing for 18 year olds.

6. Delivery systems

   NA in M-SCHIP.

   S-SCHIP is the same as Medicaid and M-SCHIP.

7. Coordination with other programs

   Department of Social Services representatives will collaborate with the Covering Kids Coalition. See 3.1.2 for description of the coalitions project.

   Department of Health coordinated with DSS to promote the new Healthy Kids Klub brochures to their local offices.

8. Crowd-out

   NA

9. Other

   NA

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs	-0-	-0-	-0-
Insurance payments	-0-	-0-	-0-
Managed care			
per member/per month rate X # of eligibles			
Fee for Service	3,570,768	5,721,078	6,855,450
Total Benefit Costs	3,570,768	5,721,078	6,855,450
(Offsetting beneficiary cost sharing payments)	-0-	-0-	-0-
Net Benefit Costs	$3,570,768	$5,721,078	$6,855,450
Administration Costs			
Personnel			
General administration	$176,337	$282,527	$338,552
Contractors/Brokers (e.g., enrollment contractors)	-0-	-0-	-0-
Claims Processing			
Outreach/marketing costs	$97,972	$156,971	$188,098
Other			
Total Administration Costs	$274,309	$439,498	$526,650
10% Administrative Cost Ceiling	399,236	635,675	761,717
Federal Share (multiplied by enhanced FMAP rate)	$3,002,661	$4,794,160	$5,621,469
State Share	$842,416	$1,366,416	$1,760,631
TOTAL PROGRAM COSTS	**$3,845,077**	**$6,160,576**	**$7,382,100**

Also see Attachment # 17: FFY 2000 HCFA - 64.21U

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

NA

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__X__ State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	M-SCHIP	S-SCHIP
Provides presumptive eligibility for children	__X__ No _____ Yes, for whom and how long?	__X__ No _____ Yes, for whom and how long?
Provides retroactive eligibility	_____ No __X__ Yes, for whom and how long? 3 months prior to the month the application is received by the Department of Social Services office.	_____ No __X__ Yes, for whom and how long? 3 months prior to the month the application is received by the Department of Social Services office.
Makes eligibility determination	__X__ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____	__X__ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____
Average length of stay on program	**Specify months** __8.5 months__ average based on a random sample of currently **active** cases as of 09-2000.	**Specify months** _____ Not sufficient data to come up with a reliable average due to the fact that S-SCHIP program was not implemented until 07-2000.
Has joint application for Medicaid and SCHIP	_____ No __X__ Yes	_____ No __X__ Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Has a mail-in application	_____No __X___Yes	_____No __X___Yes
Can apply for program over phone	__X___No _____Yes	__X___No _____Yes
Can apply for program over internet	__X___No , however, the application can be printed from the Internet Web site ,completed and then returned by fax, mail, or hand delivered to the local Department of Social Service office. _____Yes	__X___No , however, the application can be printed from the Internet Web site, completed, and then returned by fax, mail, or hand delivered to the local Department of Social Service office. _____Yes
Requires face-to-face interview during initial application	___X__No _____Yes	__X___No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	__X___No _____Yes, specify number of months _____ What exemptions do you provide?	_____No __X___Yes, specify number of months __3 months without group insurance____ What exemptions do you provide? Good cause for dropping insurance under a group health plan exists if the insurance is dropped for reasons beyond the caretaker's control. Reasons for dropping the insurance includes circumstances such as the following: (1) the cost of the insurance to cover the parent's children exceeds five percent of the S-SCHIP unit's gross income; (2) The parent providing the primary insurance is fired; (3) The parent providing the primary insurance voluntarily quits a job and has not started a new job; (4) The parent providing the primary insurance is laid off; (5) The parent providing the primary insurance becomes disabled; (6) The parent providing the primary insurance dies; (7) The parent providing the primary insurance starts a new job and there is a lapse in insurance or the new employer does not provide dependent coverage; or (8) The employer discontinued the insurance.
Provides period of continuous	__X___No	__X___No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
coverage <u>regardless of income changes</u>	_____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	_____Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	__X__No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____ ___	__X__No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____ _____
Imposes copayments or coinsurance	_X____No _____Yes	_X____No _____Yes
Provides preprinted redetermination process	__X____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	__X___ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

Annual redeterminations are completed after 12 months of eligibility. The information required and the redetermination process is very similar to the initial enrollment process. However, the Department of Social Services during the 11th month of eligibility, initiates the redetermination process by mailing a redetermination packet to families whereas in the initial application process the family initiates the process. The redetermination process is completed prior to the end of the original eligibility period so families receive

timely notice and there is no break in coverage if eligibility continues. Eligibility for Medicaid, , M-SCHIP and S-SCHIP will be reviewed during the redetermination process and the children enrolled in the appropriate coverage program. Children who had been eligible for S-SCHIP will have Medicaid eligibility reviewed at redetermination, and if Medicaid eligible, will be enrolled in the Medicaid program.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child=s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	_140__% of FPL for children under age __ 19_____ ____% of FPL for children aged _____ ____% of FPL for children aged _____
Medicaid SCHIP Expansion	_140___% of FPL for children aged ___19_____ ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	_200___% of FPL for children aged ___19_____ ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes _X__ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$ 90.00 or 20% of Gross which ever is larger	$ 90.00 or 20% of Gross which ever is larger	$ none

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Self-employment expenses	$ Deductions from self-employment: To determine net income from self-employment, subtract the costs of producing the income from the gross income. Costs of producing the income include the cost of merchandise and building or equipment rental, but do not include depreciation, personal shelter expenses, or the purchase of capital assets, such as a building, equipment, machinery, or property. Personal expenses, such as income tax, social security tax, lunches, and transportation to and from work are not considered a cost of producing income.	$ Deductions from self-employment: To determine net income from self-employment, subtract the costs of producing the income from the gross income. Costs of producing the income include the cost of merchandise and building or equipment rental, but do not include depreciation, personal shelter expenses, or the purchase of capital assets, such as a building, equipment, machinery, or property. Personal expenses, such as income tax, social security tax, lunches, and transportation to and from work are not considered a cost of producing income.	$ Deductions from self-employment: To determine net income from self-employment, subtract the costs of producing the income from the gross income. Costs of producing the income include the cost of merchandise and building or equipment rental, but do not include depreciation, personal shelter expenses, or the purchase of capital assets, such as a building, equipment, machinery, or property. Personal expenses, such as income tax, social security tax, lunches, and transportation to and from work are not considered a cost of producing income.

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Alimony payments Received	$ 50.00 of the combined alimony payment received and child support payments received is disregard.	$ 50.00 of the combined alimony payment received and child support payments received is disregard.	$ 50.00 of the combined alimony payment received and child support payments received is disregard .
Paid	$ actual court ordered amount paid out	$ actual court ordered amount paid out	$ actual court ordered amount paid out
Child support payments Received	$ 50.00 of the combined alimony payment received and child support payments received is disregard.	$ 50.00 of the combined alimony payment received and child support payments received is disregard.	$ 50.00 of the combined alimony payment received and child support payments received is disregard.
Paid	$ actual court ordered amount paid out	$ actual court ordered amount paid out	$ actual court ordered amount paid out
Child care expenses	$ actual amount due to employment	$ actual amount due to employment	$ actual amount to a maximum of $500.00 due to employment
Medical care expenses	$ -0-	$ -0-	$ -0-
Gifts	$ 30.00 per quarter per household member	$ 30.00 per quarter per household member	$30.00 per quarter per household member
Other types of disregards/deductions (specify)	$ Earnings of dependent children; earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America); earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista); income from college	$ Earnings of dependent children; earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America); earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g.,	$ Earnings of dependent children; earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
	work-study programs; education assistance programs administered by the Department of Education; education loans and awards; earned income tax credit (EITC); in-kind income if unearned; welfare cash benefits (TANF); Supplemental Security Income cash benefits; housing subsidies; foster care cash benefits; adoption assistance cash benefits; emergency or disaster relief benefits; low income energy assistance payments.	AmeriCorps, Vista); income from college work-study programs; education assistance programs administered by the Department of Education; education loans and awards; earned income tax credit (EITC); in-kind income if unearned; welfare cash benefits (TANF); Supplemental Security Income cash benefits; housing subsidies; foster care cash benefits; adoption assistance cash benefits; emergency or disaster relief benefits; low income energy assistance payments	America); earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista); income from college work-study programs; education assistance programs administered by the Department of Education; education loans and awards; earned income tax credit (EITC); in-kind income if unearned; welfare cash benefits (TANF); Supplemental Security Income cash benefits; housing subsidies; foster care cash benefits; adoption assistance cash benefits; emergency or disaster relief benefits; low income energy assistance payments

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups __X__No ____Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program	_ X__No	____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program	_ X__No	____Yes, specify countable or allowable level of asset test_____
Other SCHIP program____NA_____	____ No	____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes _X__ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage

   None

2. Employer sponsored insurance buy-in

   None

3. 1115 waiver

   No

4. Eligibility including presumptive and continuous eligibility

   No

5. Outreach

   The Community Healthcare Association of Sioux Falls, South Dakota was a successful applicant for the 'South Dakota Covering Kids Initiative' through grant funding from the Robert Wood Johnson foundation for a three-year period of time form July 1, 2000 through June 30, 2003. The South Dakota Covering Kids Initiative has four goals. They are: designing and conducting outreach programs to identify and enroll children in the Medicaid land SCHIP programs; continuing to simplify access to and completion of enrollment information and applications; assisting in coordinating coverage programs for low income, uninsured children; and designing programming specifically targeted to Native Americans and other special populations. The program will feature statewide initiatives to meet these goals and also pilot programs to address specific geographic areas and special populations.

6. Enrollment/redetermination process

   Future plans are to create a simplified and shortened redetermination form in order to assure continuous coverage of eligible children in both the M-SCHIP and S-SCHIP programs.

7. Contracting

   No

8. Other

NA